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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF THE STATE OF WISCONSIN AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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QUESTIONS PRESENTED

I. Whether the Eighth Circuit's adoption of a broad unconstitutional reading of Nebraska's ban on partial-birth abortion, which directly conflicts with the narrower constitutional construction of similar statutes by the Seventh Circuit Court of Appeals and that of the State officials charged with enforcement of the statute, violates fundamental rules of statutory construction and basic principles of federalism in contradiction of the clear direction of this Court in *Webster v. Reproductive Health Services*?

II. Whether the Eighth Circuit misapplied this Court's instructions in *Planned Parenthood v. Casey* by finding that a law banning cruel and unusual methods of killing a partially-born child, is an "undue burden" on the right to abortion?

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Pursuant to Supreme Court Rule 37, the State of Wisconsin submits this brief as *amicus curiae* in support of petitioners.

STATEMENT OF INTEREST OF *AMICUS CURIAE*

The State of Wisconsin has a strong interest in the Court's construction of Nebraska's statute limiting partial-birth abortions, the Court's consideration of federalism principles as they relate to partial-birth abortion statutes, and the Court's application of the "undue burden" test of *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), to partial-birth

abortion statutes, because the State of Wisconsin enacted a partial-birth abortion statute that has withstood a challenge at the district court and court of appeals levels when construed in accordance with the Wisconsin Legislature's intent. Wisconsin's partial-birth abortion statute was enacted to limit only one rare method of abortion, known medically as "D&X" (dilation and extraction), while other alternative methods remain available.

The State of Wisconsin has an interest in presenting to this Court a partial-birth abortion statute with language different from Nebraska's statute, and a trial record that includes the testimony of the abortion providers themselves showing that partial-birth abortion statutes are not vague to them and can be enforced without posing an undue burden on women seeking abortions.

SUMMARY OF ARGUMENT

While women have a constitutional right to have abortions, they do not have a constitutional right to a particular type of abortion that a State legislature has determined is less safe than other available methods and offends the public morality.

The evidence introduced at trial in *Planned Parenthood v. Doyle*, 44 F. Supp.2d 975 (W.D. Wis. 1999), *vacated and remanded sub nom. Hope Clinic v. Ryan*, 195 F.3d 857 (7th Cir. 1999) (en banc), showed that the medical community, including plaintiff abortion providers and their experts, knows what a partial-birth abortion is when they are practicing medicine outside of the courtroom. The documentary and testamentary evidence revealed that only one method of abortion fits the Wisconsin statute's definition of partial-birth abortion, and that is known by the medical term D&X (dilation and extraction) abortion. Contrary to the conclusion of the Eighth Circuit in this case, a D&E (dilation

and evacuation) abortion does not fall within the definition of partial-birth abortion.

The State of Wisconsin was able to show that it has interests in maternal health, potential life and morality that are furthered by the enactment of Wisconsin's partial-birth abortion statute. The evidence illustrated that while the D&X method of abortion may have some theoretical benefits over other methods of abortion, those theories have not yet been borne out by results. The evidence was clear that all the testifying physicians who held hospital privileges preferred the induction method of abortion at the gestational ages when D&X abortions are performed (twenty to twenty-four weeks), even if they declared that there are theoretical benefits to D&X abortions. Physicians without hospital privileges indicated that the biggest factor in determining whether to use the D&X or D&E method of abortion was whether after two days of dilation a D&E could be performed safely and thereby the woman could avoid the "inconvenience" of having to return a third day when there would be more dilation and a D&X abortion could be performed.

The evidence presented at the trial in Wisconsin showed that a D&X abortion is never the only safe option for a woman seeking an abortion. Plaintiffs were unable to present any evidence of a situation where a partial-birth abortion was necessary to preserve the health of a pregnant woman.

States' partial-birth abortion statutes do not have the purpose or effect of imposing an undue burden on women seeking abortions, but intend only to limit the availability of one rare method of abortion that comes close to infanticide. Despite the fact that respondents' counsel in this case have been involved in litigation over States' partial-birth abortion statutes around the country, they were unable to show that the Wisconsin partial-birth abortion statute had the effect of placing a substantial obstacle in the path of women seeking abortions. During the period of time Wisconsin's statute was

in effect the physicians continued to provide abortions to pregnant women at all weeks of gestation. No physician reported an increase in morbidity/mortality rates while the statute was in effect.

The record in *Planned Parenthood v. Doyle* showed that a partial-birth abortion statute can be construed to apply only to the D&X method of abortion and under such construction is not an undue burden on women seeking abortions, an issue never reached by the Eighth Circuit in *Carhart v. Stenberg*, 192 F.3d 1142 (8th Cir. 1999).

The decision below should be reversed.

ARGUMENT

I. THE DEFINITIONS OF PARTIAL-BIRTH ABORTION IN STATES' STATUTES ARE NOT UNCONSTITUTIONALLY VAGUE.

A. THE DOCUMENTARY EVIDENCE AND THE TESTIMONY OF PLAINTIFF ABORTION PROVIDERS SHOWS THAT THEY KNOW WHAT A PARTIAL-BIRTH ABORTION IS UNDER VARIOUS STATES' STATUTES.

The definitions of partial-birth abortion in States' partial-birth abortion statutes use commonly understood terms

to describe the method of abortion they seek to limit.[1] Wisconsin's statute, like many other States', requires that a child first be intentionally partially vaginally delivered, then intentionally killed, then fully delivered. Wis. Stat. § 940.16.

On the witness stand, several Wisconsin plaintiff physicians admitted they understood the meaning of the terms used in Wisconsin's statute and agreed that the statute required three acts in sequence. The medical term for a partial-birth abortion is a D&X abortion (or intact D&E abortion). Plaintiffs know what a D&X abortion is and do not dispute that it fits the statutory definition. The exhibits introduced at trial illustrate that the medical community, and indeed several of plaintiffs' witnesses themselves, know what a partial-birth abortion is in a context outside of the courtroom.[2]

Plaintiff Dr. Broekhuizen, a professor of Obstetrics and Gynecology at the University of Wisconsin Medical School, was asked "[i]s there any individual term in the definition of a partial-birth abortion that you do not understand" to which he

---

[1] *See, e.g.*, Wis. Stat. § 940.16 Partial-birth abortion. (1) In this section:

(a) "Child" means a human being from the time of fertilization until it is completely delivered from a pregnant woman.

(b) "Partial-birth abortion" means an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes the delivery of the child.

(2) Except as provided in sub. (3), whoever intentionally performs a partial-birth abortion is guilty of a Class A felony.

(3) Subsection (2) does not apply if the partial-birth abortion is necessary to save the life of a woman whose life is endangered by a physical disorder, physical illness or physical injury, including a life-endangering physical disorder, physical illness or physical injury caused by or arising from the pregnancy itself, and if no other medical procedure would suffice for that purpose.

[2] "Both medical and popular literature equate 'partial-birth abortion' (the statutory term) with the D&X procedure." *Hope Clinic v. Ryan*, 195 F.3d at 865 (citations omitted).

answered "[n]o, I understand that in layman's term, yeah, that that—I understand every term that's being written down here" (Tr. 115[3]). Plaintiff Dr. Jacobson "can understand individually each term in the definition of 'partial-birth abortion' in Wis. Stat. § 940.16" (Stip. ¶ 102).

Plaintiff Christensen issued a press release on May 21, 1998, after initiating the Wisconsin lawsuit, that admits that he knows exactly what procedure the statute is limiting:

> After carefully weighing the medical needs of my patients, the personal legal risks and the political consequences relative to the public abortion debate, I have decided to resume providing a full range of abortion services through the 24th menstrual week of pregnancy. In order to avoid prosecution under the so called "partial birth" abortion law I have been forced to alter the surgical technique, with the consent of the patient, so that procedure will not fall within the scope of the law even if the change results in a sub-optimal procedure which increases the risks.

(Ex. 208).

Plaintiffs' expert (in both this case and the Wisconsin case), Dr. Phillip Stubblefield, agreed with the statement written by David Grimes, M.D., (described by Stubblefield as an expert in the field of abortion), that "some federal and state legislators have attempted to ban intact D&E" (referring to Ex. 207). Dr. Stubblefield himself wrote a chapter for an OB/GYN

[3] Citations to "Tr." are to the transcript of the May 27, 1999, trial before the district court in Wisconsin, to "Ex." are to exhibits entered into evidence at that trial, to "Stip." are to the parties' Amended Joint Pretrial Stipulation of Facts, and to "Stubblefield Tr." are to the trial testimony of Dr. Stubblefield given by deposition on May 7, 1999.

medical textbook providing "[t]he breech extraction variation of intact D & E, described in the lay press as 'partial birth abortion' has been made illegal in several states" (Ex. 239). Dr. Stubblefield replied in the affirmative to the question "[w]ould you agree with the statement that some members of the medical community refer to D&X as partial birth abortion" (Stubblefield Tr. 92).

Plaintiffs' expert Dr. Martin Haskell (who pioneered the D&X method) replied "[s]ure. Yes." to the question whether he would agree with the statement that "some federal and state legislators have attempted to ban intact D&E" (Tr. 41). Dr. Haskell even wrote a letter to Congressman Canady at the time of the federal deliberations on partial-birth abortion in which he indicated he knew exactly what method of abortion was being referred to as partial-birth abortion:

> Recently, your committee held a hearing regarding a procedure that you refer to as a partial birth abortion.
>
> . . . .
>
> [T]he original paper is over three years old. The procedure has continued to evolve in refinement since then. Statements that fetuses are not dead until nearly the end of the procedure are not accurate. Death occurs early in the procedure if not before. Representations that fetuses are living, conscious, feeling pain, wiggling, kicking or trying to escape are totally fictitious.

(Ex. 202 at 24-25).

The expert retained by the State of Wisconsin, Dr. Harlan Giles,[4] testified on cross-examination that he and the rest of the informed medical community know what partial-birth abortion means:

> Q Is it your understanding that the term partial-birth abortion has some commonly understood meaning within the medical community?
>
> A I think the medical community has come to understand that term in the last few years. I don't think it was something that appeared anywhere in our literature until just very recently.
>
> Q But you think there's some sort of a relative consensus now about what that term means in the medical community?
>
> A I would think so.
>
> Q What is that? What is the meaning of partial-birth abortion that is—that there's consensus about in the medical community?
>
> A That in the process of terminating the pregnancy that a portion of the fetus is delivered into the vagina and then a

[4] Dr. Giles testified as an expert in obstetrics, gynecology, maternal fetal medicine, abortion procedures and prenatal genetics. Dr. Giles is a professor and associate dean of medical education at the Medical College of Pennsylvania and Hahnemann University, Allegheny University of Health Sciences. Dr. Giles is also a clinical professor in the Department of Obstetrics and Gynecology at the University of West Virginia School of Medicine. Dr. Giles is a fellow of the American College of Obstetricians and Gynecologists (ACOG).

> specific procedure is undertaken that will kill the fetus prior to completing the delivery.
>
> Q And is it your impression that the term D&X is also widely understood to have a single meaning within the medical community?
>
> A In a general way, yes, I think so.
>
> Q And what is that meaning?
>
> A Pretty much the same meaning I gave to partial-birth abortion; that is, delivering a portion of the fetus into the vagina and specifically carrying out a procedure such as evacuating the brain contents or cutting the umbilical cord which has the express purpose of killing the fetus before completing the delivery.

(Tr. 209-10).

The literature of the medical community has recognized that the partial-birth abortion debate refers to D&X abortions (sometimes called intact D&E abortions), although some of the publications post-date the trial in *Carhart v. Stenberg* (*see, e.g.,* Ex. 240, Annas, "Partial-Birth Abortion, Congress, and the Constitution," *Legal Issues in Medicine*[5]). Introduced into evidence at the trial in Wisconsin was an article by Stanley Henshaw of the Alan Guttmacher Institute, described by plaintiffs as an institute that does "a lot of demographic and surveillance studies about abortion" (Tr. 41), in which Henshaw states that the "medically accepted term

[5] This article was published in Vol. 339, No. 4 on July 23, 1998, after the March 24, 1998 trial in *Carhart v. Stenberg*.

intact dilatation and extraction D&X as defined by the ACOG is the only procedure that approximates the various descriptions of partial-birth abortion" (Tr. 41; Ex. 230 at 269).[6] The Journal of the American Medical Association (JAMA) itself published a symposium of articles on the subject, making it clear that partial-birth abortion legislation is directed at the D&X abortion method (*see* Exs. 205-07).[7]

The American College of Obstetricians and Gynecologists ("ACOG") concluded that "the intent of such legislative proposals [limiting partial-birth abortions] is to prohibit a procedure referred to as 'Intact Dilatation and Extraction' (Intact D & X)" (Ex. 16). Similarly, the American Medical Association understands what procedure is subject to the statutes at issue:

> The term "partial birth abortion" is not a medical term. The American Medical Association will use the term "intact dilatation and extraction" (or intact D&X) to refer to a specific procedure comprised of the following elements: [then delineating the same steps described by the ACOG]. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester.

Rpt. of the Bd. of Trustees on Late-Term Pregnancy Termination Techniques, May 1997 (Ex. 17). The AMA Report specifically distinguishes the D&X method of abortion from other methods saying "[o]ne feature that distinguishes the D&X procedure from other destructive procedures is that the

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[6] "Abortion Incidence and Services in the United States, 1995-1996," published Nov./Dec. 1998, after the March 24, 1998, trial in *Carhart v. Stenberg*.

[7] This symposium of articles was published in JAMA, Vol. 280, August 26, 1998, after the March 24, 1998, trial in *Carhart v. Stenberg*.

fetus may be partly outside the woman's body" (Ex. 17). Plaintiff Broekhuizen stated that he "agree[d] with that statement" (Tr. 120).

In short, the medical community, including plaintiff physicians, knows that the challenged partial-birth abortion statutes limit the method of abortion known to physicians as D&X (or intact D&E). "Indeed, the district court in Wisconsin found as a matter of fact that physicians who are likely to perform an abortion already understand that this [D&X] is the point of partial-birth abortion statutes. 44 F. Supp.2d at 978. That finding cannot be set aside as clearly erroneous." *Hope Clinic v. Ryan*, 195 F.3d at 868.

B. THE D&X METHOD OF ABORTION IS DISTINCT FROM THE D&E METHOD: ONLY IN THE D&X METHOD DO PHYSICIANS INTENTIONALLY KILL AN INTACT CHILD WHILE IT IS IN THE VAGINAL CANAL.

The Eighth Circuit in this case found that the definition of partial-birth abortion in Nebraska's statute would apply not only to D&X abortions, but also to D&E abortions, and therefore held Nebraska's statute unconstitutional. However, as plaintiffs described the various abortion methods in the Wisconsin litigation, it was clear that only in the D&X method does the physician intend to kill the child at a certain point, *i.e.* while in the vaginal canal, and intend to complete delivery of the intact child. In all other methods plaintiffs described (D&E, induction, suction curettage/vacuum aspiration), the

child's death occurs at different times and from different causes.[8]

In contrast to plaintiffs' definition of a D&X (or intact D&E) abortion[9], plaintiffs' definition a D&X abortion describes the partial delivery of an intact child, an act done by a physician while the child is partially delivered that will kill the intact child, and then the completion of the delivery of the intact child:

> In the intact D&E procedure (which is also known as "dilation and extraction," "D&X" or "intact D&X"), the physician dilates the cervix and then removes the fetus from the uterus through the vaginal canal *intact*. The physician extracts the fetal body *intact*, usually feet first, until the cervix is obstructed by the aftercoming head, which is too large to pass through the cervix. Then the physician creates a small opening at the base of the skull and evacuates the contents, allowing the calvarium to pass through the cervical opening. *The intentional*

[8] The Seventh Circuit described the uniqueness of the D&X method of abortion: "Central to the D&X procedure [is] that an intact fetus moves from uterus to vagina before death occurs." *Hope Clinic v. Ryan*, 195 F.3d at 863. "It is this combination of coming so close to delivering a live child with the death of the fetus by reducing the size of the skull that not only distinguishes D&X from D&E medically but also causes the adverse public (and legislative) reaction." *Id.* at 862.

[9] "The most common method of second-trimester abortion is the dilation and evacuation (D&E) procedure" (Stip. ¶ 35). "In a D&E procedure, the physician generally dilates the cervix by inserting laminaria (an osmotic dilator placed in the woman's cervix, which absorbs natural moisture and expands, dilating the cervix)" (Stip. ¶ 36). The laminaria remain in overnight. After the laminaria are removed, the physician will use a vacuum curette to rupture the membranes (amniotic sac) (*id.*). The physician will use forceps to grasp and remove the remainder of the child from the uterus (Stip. ¶ 37). The D&E usually involves dismemberment of the child and repeated insertions of the forceps into the uterus (Stip. ¶ 37).

> *removal of the fetus intact is what distinguishes an intact D&E procedure from a D&E procedure.*

(Stip. ¶ 65; Christensen Decl. ¶ 9; Smith Decl. ¶ 9 (emphasis added).) Plaintiffs' expert Dr. Stubblefield agreed with the statement that "the D&X procedure is distinct from the D&E procedure" (Stubblefield Tr. 98). He indicated the "goal" of a D&X "is to modify the D&E procedure in a way that the fetus is delivered essentially intact rather than dismembered into pieces" (Stubblefield Tr. 9).

The practitioner who coined the term "Dilation and Extraction or D&X" did so to distinguish it from "dismemberment-type D&E's." (Ex. 204, Haskell "Dilation and Extraction for Late Second Trimester Abortions.") Dr. Stubblefield agreed with the statement in Dr. Haskell's paper that "[t]he surgical method described in this paper differs from classic D&E in that it does not rely upon dismemberment to remove the fetus" (Stubblefield Tr. 90).

Plaintiffs specifically distinguish the D&E from the D&X by the element of intent, and Wisconsin's statute does the same by requiring the intentional performance of a partial-birth abortion. Wis. Stat. § 940.16(2). The scienter requirement of partial-birth abortion statutes ensures that the statutes are not unconstitutionally vague. Contrasting plaintiffs' definitions of D&E abortions to their definition of D&X abortions, it becomes clear that only in performing D&X abortions do physicians *intentionally* partially deliver a *living* child or are "practically certain" to do so.

The Attorneys General of Wisconsin and Illinois stipulated that under their respective States' laws "a procedure may be deemed a 'partial-birth abortion' only if at the outset of the procedure the physician intends to perform all of the steps that mark the D&X." *Hope Clinic v. Ryan*, 195 F.3d at 867. By contrast, the Eighth Circuit found in this case that "[a]

physician need not set out with the intent to perform a D&X procedure in order to violate the statute. It is enough that the physician have the intent to deliver vaginally a substantial portion of a living fetus, and that occurs in the D&E procedure." *Carhart v. Stenberg*, 192 F.3d at 1150.

Plaintiffs in the Wisconsin case claimed that the phrase "partially vaginally delivers a living child" is vague because it does not distinguish between situations where a fetal part is delivered into the birth canal and situations where a portion of an intact fetus is delivered into the birth canal (*see, e.g.*, Christensen Decl. ¶ 17 (Ex. 214)) (Similar claims were made in this case. *Carhart v. Stenberg*, 192 F.3d at 1150[10]). Interpreting "partially" to include dismembered parts of a child ignores that the definition of "partial-birth abortion" continues after the challenged phrase: "'Partial-birth abortion' means an abortion in which a person partially vaginally delivers a living child, causes the death of the partially delivered child with the intent to kill the child, and then completes the delivery of the child." Wis. Stat. § 940.16(1)(b). The "*living* child" phrase tells the doctor that a dismembered part of a body of a child that may wind up in the vaginal canal is not part of the relevant definition. Furthermore, the deliberate causing of the death to the partially delivered child would indicate that a dismembered part of a child is not within the scope of the language because

[10] Nebraska's statute prohibits a person from "'deliberately and intentionally delivering into the vagina a living unborn child, *or a substantial portion thereof*, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.' Neb. Rev. Stat. § 28-326(9) (1998)." *Carhart v. Stenberg*, 192 F.3d at 1150 (emphasis added). The Eighth Circuit held that "[t]he *crucial* problem is the term 'substantial portion'" and found that an arm or a leg is "substantial." *Id.* (emphasis added).

Wisconsin's statute does not contain the "substantial portion" language that troubled the Eighth Circuit. *See* Wis. Stat. § 940.16(1)(b). The Wisconsin statute requires the delivery of an intact body into the vagina. Wis. Stat. § 940.16(1)(b).

no doctor could reasonably claim that he causes the death of a dismembered part of a child. *See Planned Parenthood v. Doyle*, 44 F. Supp.2d at 985. The final act, completing delivery of the *child*, could not be done if the physician were just completing delivery of a dismembered part of a fetus.

For a D&E to fall within the definition of a partial-birth abortion in Wis. Stat. § 940.16(1)(b), courts would have to read the term "partially vaginally delivers a living child" to include the removal of dismembered parts of the fetus, and would have to equate the performance of any abortion with "causes the death of the partially delivered child with the intent to kill the child."

The Wisconsin statute's required sequencing of events—that the intentional killing follow the partial delivery and precede the completion of delivery of the child—further clarifies that D&Es are not contemplated by the statute. In performing D&E abortions a physician is not "practically certain" that he will cause the death of a partially delivered child. Plaintiff Dr. Broekhuizen testified that when he begins a D&E procedure he does not know at what point he will kill the child (Tr. 122). Similarly, plaintiff Drs. Christensen and Smith submitted affidavits indicating they do not know at what point a child dies during their performance of D&E abortions (Christensen Decl. ¶ 8 (Ex. 214); Smith Decl. ¶ 8 (Ex. 219)).

Dr. Stubblefield testified for plaintiffs that when a doctor begins a D&E procedure he does not know when the child will die (Stubblefield Tr. 70). Dr. Stubblefield testified about D&Es that "detaching a limb, that's going to cause bleeding, but it's not going to immediately kill the fetus. . . . Evulsing one limb may not result in the death of the fetus for awhile. Perhaps evulsing the second limb will result in the death of the fetus sooner" (Stubblefield Tr. 45-46). By contrast, Dr. Stubblefield testified that in a D&X there is a step one takes that he knows will kill the child (Stubblefield Tr.

114)—the child will "certainly die when the skull is crushed" (Stubblefield Tr. 46).

> When a physician employs the "D&X" (by any definition), fetal cardiac activity and other signs of fetal life may continue after the fetus has been extracted intact up to the skull and before the skull is punctured or crushed. Under these circumstances, all fetal cardiac activity and all other signs of life eventually cease as a result of the steps the physician takes to crush the skull or evacuate the contents of the skull.

(Stip. ¶ 67). Dr. Broekhuizen testified for plaintiffs that if the child is alive at the point of decompression of the head in the D&X procedure then the decompression will certainly kill the child (Tr. 123).

Dr. Giles testified:

Q In a D&E abortion does a physician ever intentionally partially deliver a living child into the vagina for purposes of there performing a procedure to kill the child?

A No.

Q In a D&E abortion where does the dismemberment of the child take place?

A Inside the uterine cavity in almost all instances.

Q In a D&E abortion can you predict or control when the death of the child will occur?

A No. In a D&E abortion there is no way in which one would predict or control the timing of the fetal demise.

Q Is there a specific point in a D&E abortion when a child dies?

A No, and in fact a fetus can be delivered with an intact D&E as I've described it and still be alive with cardiac activity after the delivery.

(Tr. 193-94.)

In contrast to the other abortion procedures, Dr. Giles testified that the D&X procedure meets the intentional description of Wis. Stat. § 940.16:

Q In a D&X procedure can you predict or control when the death of the child will occur?

A Yes.

(Tr. 198.)

In sum, plaintiffs' definition of D&X abortions, when contrasted with plaintiffs' definition of D&E abortions, makes clear that the definition of partial-birth abortion in Wis. Stat. § 940.16 is not vague and does not include the common, conventional D&E abortions. Wisconsin Stat. § 940.16 did not criminalize the happenstance of a child dying in the birth canal.

II. LIMITING THE AVAILABILITY OF THE PARTIAL-BIRTH METHOD OF ABORTION TO CIRCUMSTANCES WHERE NECESSARY TO PRESERVE A WOMAN'S LIFE IS NOT AN "UNDUE BURDEN."

States have a "profound interest in potential life." *Planned Parenthood v. Casey*, 505 U.S. at 878. States have "legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child." *Id.* at 846. States "may enact regulations to further the health or safety of a woman seeking an abortion. Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." *Id.* at 878.

Under this analysis the undue burden test as applied to partial-birth abortion regulations would inquire: (1) whether the States' statutes are reasonably related to a legitimate state interest or whether the statutes have the purpose of placing a substantial obstacle in the path of a woman seeking an abortion; and (2) whether the States' statutes have the effect of placing a substantial obstacle in the path of a woman in seeking an abortion. The Eighth Circuit in this case did not reach the issue of whether it is an undue burden to limit the availability of one method of abortion when other equally safe or safer methods are still available because it read Nebraska's partial-birth abortion statute to limit D&Es as well as D&Xs.

A. THE D&X METHOD OF ABORTION IS NO SAFER THAN OTHER AVAILABLE ALTERNATIVES. TESTIMONY OF THE ABORTION PROVIDERS SHOWED THAT THERE ARE ALWAYS EQUALLY SAFE OR SAFER ALTERNATIVES TO PARTIAL-BIRTH ABORTIONS, WHICH THEY THEMSELVES REGULARLY USE.

States' partial-birth abortion statutes have been challenged on the grounds that they do not promote maternal health because the D&X abortion method, which the statutes limit, is safer than the classic D&E abortion method. However, testimony at trial in Wisconsin proved that the D&X procedure the Wisconsin Legislature limited is not safer than other abortion procedures available to women. Plaintiffs' and their experts' medical practices did not support their claim that the D&X abortion method was safer than other available methods. The Wisconsin plaintiff physicians who are qualified and providing a full range of OB/GYN services are doing *induction* abortions and those who only perform abortions are doing D&E abortions with rare exceptions.

The testimony of Dr. Stubblefield (plaintiffs' expert in both the Wisconsin case and this one), showed that the safety of the D&X method was only theoretical. Dr. Stubblefield offered only qualified, equivocal support for a procedure that he does not employ. Dr. Stubblefield could not state that it was a medically accepted fact that D&X abortion was safer than other available procedures (Stubblefield Tr. 96). Dr. Stubblefield testified that his "feeling" is that from twenty to twenty-four weeks D&X is safer than D&E. "So that I think in general it may turn out to be a safer way to provide abortion at that gestational age" (Stubblefield Tr. 18). *See also id.* at 20 (D&X "would appear to offer some distinct advantages"). Stubblefield candidly admitted that D&X is at an "early stage"

of the "progress of science in clinical medicine" and eventually it may emerge as an improved procedure (Stubblefield Tr. 26). Stubblefield testified that to be "really clear" on advantages of D&X the "next step of actually comparing [D&E and D&X], preferably in a random basis in the same center" would have to be taken (Stubblefield Tr. 26-27).

Dr. Stubblefield "can recall one occasion when he performed the head-first version of the D&X as he described it," but the fetus was dead when he punctured the skull (Stip. ¶ 82).[11] Dr. Stubblefield "has never performed a D&X on any other occasion" nor has he "seen a D&X performed on any other occasion" (Stip. ¶¶ 83-84). "Dr. Stubblefield has never offered a D&X abortion to one of his patients as an option," nor has he ever "referred a patient to another physician to have a D&X abortion performed" (Stip. ¶¶ 85-86). Aside from testimony in partial-birth abortion cases, Dr. Stubblefield has never testified about the safety of a surgical procedure that he never tried (Stubblefield Tr. 97).

Dr. Stubblefield, members of his faculty and residents under his supervision, perform D&E abortions through seventeen weeks gestation and at weeks eighteen to twenty perform induction abortions; they do not perform abortions later than twenty weeks (Stip. ¶ 87). In Dr. Stubblefield's practice they "are getting good enough results with overnight placement of laminaria tents and the amount of dilatation that accomplishes to allow [them] to do standard D&E reasonably expeditiously," (Stubblefield Tr. 41-42), they do not wait the extra day to do the D&X:

> Q So in the medical sense what is the trade-off between increased time for dilatation and access to the D&X procedure?

[11] The abortion did not preserve the woman's health and Dr. Stubblefield performed a hysterectomy the next day (Stubblefield Tr. 30).

> A That in fact is the trade-off. The patient is investing more time prior to the uterine evacuation procedure in order to do a D&X, another day or more spent wearing laminaria to accomplish the additional dilatation in order to have a briefer procedure of uterine evacuation with less need for instrumentation in the uterus.

(Stubblefield Tr. 42). "Since we use D&E only up to 17 weeks, our decision is that it's not worth the additional day for the patient—day or more—to accomplish the amount of dilatation needed for the D&X procedure, so we choose to stick with conventional D&E" (Stubblefield Tr. 75). Dr. Stubblefield is familiar with OB/GYN residency programs around the country and is not aware of any program that is teaching D&X abortions (Stubblefield Tr. 97).

Dr. Stubblefield also testified that at the same week of gestation "the D&X requires greater dilatation" than the D&E (Stubblefield Tr. 72), which supports the Wisconsin district court's conclusion about increased risk of cervical incompetence and increased risk that a woman's membranes may rupture. *Planned Parenthood v. Doyle*, 44 F. Supp.2d at 979.

Dr. McMahon's 1995 report, "Intact D&E: The First Decade," which plaintiffs introduced into evidence, concludes "[i]s intact D&E better than the classical disruptive D&E? It depends upon the circumstances. Late in pregnancy, it may be the preferred method. Additional data is necessary" (Ex. 18 at 24). Dr. Stubblefield agreed that that statement is still true today (Stubblefield Tr. 84). Dr. Stubblefield also stated he agreed with the summary in Dr. Haskell's report that "among its [D&X's] disadvantages are that it . . . requires a high degree of surgical skill, and may not be appropriate for a few patients" (Stubblefield Tr. 91, referring to Ex. 204).

Dr. Stubblefield testified that for gestational age twenty to twenty-four weeks (when D&X abortions are performed) "it's not been possible to say that the D&E is safer than labor induction. They really appear to be about comparable when you talk about major risks" (Stubblefield Tr. 18). There is no basis for concluding that D&X abortions are safer when D&E abortions are available, and even D&Es have not been shown to be safer than induction abortions.

Dr. Stubblefield was asked the following questions and gave the following answers:

> Q If you would take as a hypothetical that the Wisconsin legislature has only limited the D&X method, then would you agree that Wisconsin has attempted to limit a procedure that has not yet been subjected to a formal peer review?
>
> A Yes.

(Stubblefield Tr. 93-94.)

> Q Has the safety of the D&X procedure ever been studied to the point where it is a medically accepted fact that it is a safer abortion method than other available abortion procedures?
>
> A No.

(Stubblefield Tr. 95-96).

"There are no published medically-recognized studies comparing the risks of D&E to D&X" (Stip. ¶ 90). Plaintiff "Dr. Broekhuizen is unaware of any peer-reviewed journal articles on D&X abortions" (Stip. ¶ 109). "Dr. Broekhuizen believes comparisons of the risks of D&E to D&X would be

valuable information," but is "unaware of any head-to-head comparison" (Stip. ¶ 113).

Dr. Broekhuizen testified that the only way we could have the answer to the question of whether the D&X is safer than the D&E is "prospective randomized trial of D&X versus D&E" (Tr. 91). Dr. Broekhuizen said without prospective randomized trials physicians must "rely on the descriptive nature and theories that have been described. But I think there's a potential that . . . could apply that D&X technique actually is safer than a D&E technique" (Tr. 88).

Dr. Broekhuizen admitted the D&X does not have the same track safety record as the D&E yet (Tr. 105) and he personally does inductions after twenty weeks; he does not set out to do D&E or D&X abortions (Tr. 105-06).

Dr. Broekhuizen testified that at the University of Wisconsin Medical School, Milwaukee clinical campus, they teach residents D&E techniques up until sixteen weeks gestation and induction, but they do not teach D&E after sixteen weeks, nor do they teach D&X (Tr. 109). Dr. Broekhuizen admitted that with doing D&Xs from twenty to twenty-four weeks there may be an increased risk for future pregnancy performance or fertility (Tr. 107). He agreed with the JAMA article that provided "[i]n the absence of controlled studies the relative advantages and disadvantages of the procedure in specific circumstances remain unknown" (Ex. 205; *see* Tr. 118).

Plaintiff Christensen testified on direct that the increased time to increase the amount of dilation required for a D&X abortion *increases* the health risks to the mother:

> A Well, there is a tradeoff between how long it takes to get the cervix dilated and how much cervical dilatation you get. . . . And so if we tried to get any

more than three centimeters' dilatation, for example, it may take us two or three days to get the cervix dilated which subjects the woman to more both psychological and potential medical trauma.

(Tr. 168.)

Q Okay. Is it your understanding that the risk to the woman of complications such as infection increases with the amount of time that's spent dilating the cervix with the laminaria?

A I believe that that is a reasonable assumption, that the longer you have a foreign body in the uterus the greater the risk of infection.

(Tr. 176).

Dr. Giles testified that after twenty weeks the induction method becomes safer and safer relative to the D&E method and D&X would carry higher risk than induction methods. (Tr. 199). In comparing the D&E to the D&X Dr. Giles testified:

Q Is it your opinion that the D&X abortion is riskier than the D&E abortion from 20 to 24 weeks of gestation?

A Yes, I do think it is more risky based on the fact that there is required intrauterine manipulation or twisting of the fetus. There is also a sharp instrument inserted, usually scissors, into the base of the skull without perfect visualization, and I think that increases

the risk of cervical or uterine tears or lacerations and an increase, may increase the risk of bleeding as well.

(Tr. 199-200).

Even the American Medical Association and doctors who perform abortions draw a line at the D&X procedure. The Report of the AMA Board of Trustees does not support use of the D&X procedure:

> According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

(Stip. ¶ 80, Ex. 17).

In short, the best evidence supporting the conclusions of the Wisconsin district court and the Seventh Circuit that the State's interest in maternal health is furthered by a statute limiting partial-birth abortions is physician plaintiffs' own testimony and practices; abortion practitioners continue to use the induction and D&E abortion methods that have proven track records on safety. The State of Wisconsin, like many other States, has enacted measures to protect the mother's health, which is constitutional.

B. THERE IS NO UNDUE BURDEN BECAUSE EQUALLY SAFE OR SAFER METHODS ARE ALWAYS AVAILABLE.

The claim that limiting D&X abortions will impose an undue burden on women is not supported by the experience of abortion providers in Wisconsin while Wisconsin's partial-birth abortion statute was in effect. During that time period, all of the plaintiffs continued to provide abortion services to all of their patients. *Planned Parenthood v. Doyle*, 44 F. Supp.2d at 980-81. Plaintiff Dr. Christensen, the only plaintiff who performs D&X abortions on a regular basis in Wisconsin (two to three a year), testified that his "rate of complications from abortions did not go up in a 'statistically significant fashion' while Wis. Stat. § 940.16 was in effect," even though he reported he would have to alter his abortion technique (Stip. ¶ 125). Moreover, as discussed above, there are always equally safe, if not safer, alternatives to the D&X abortion.

As the district court noted, neither the American Medical Association, nor the American College of Obstetricians and Gynecologists could identify a medical situation in which the D&X abortion would be the only appropriate procedure. *See Planned Parenthood v. Doyle*, 44 F. Supp.2d at 980.

Plaintiffs' testimony supported this conclusion. Neither plaintiffs nor their experts had encountered a situation in which a D&X abortion was necessary to preserve the health of a woman. For example, plaintiff Dr. Smith testified at trial:

> Q Have you ever encountered a situation where you thought that that procedure [D&X] might be better for one of your patients than a procedure you do?

> A As of my experience today, no.

(Tr. 148). Plaintiffs' expert Dr. Haskell testified that he has never encountered a situation where a D&X was medically necessary to achieve the desired outcome (Tr. 71).

Dr. Giles testified that he has "delivered fetuses at literally every week of gestational age . . . I've never faced a situation in which the D&X procedure as I understand it would be necessary . . . ." (Tr. 199). Not only would it not be necessary, it would not even be "preferable to other conventional obstetrical techniques." (Tr. 200-01).

Dr. Giles was specifically asked:

> Q Can you conceive of a medical situation where a D&X would be medically beneficial to the woman's health?
>
> A No, I honestly can't, and I've given it a lot of thought.
>
> Q With respect to prenatal genetics is there any advantage to the D&X method of abortion?
>
> A No, it's disadvantageous because following the evacuation of the cranial vault it is no longer possible to study any part of the brain to determine whether there are any malformations of the central nervous system.

(Tr. 202).

Dr. Giles testified that Wisconsin's statute would not be a burden on women in Wisconsin:

> Q If the State of Wisconsin limits the D&X procedure is it doing something harmful to the health of women in Wisconsin?
>
> A No, I don't think that the statute as I read it would have any negative impact on the health care of women in the state of Wisconsin nor their access to abortion services.

(Tr. 207).

Plaintiff Dr. Smith reported that "[i]n general the D&E is considered the safest procedure, especially in comparison to induction" (Stip. ¶ 94). "Physicians with experience always have the option of converting an intact procedure to a dismemberment procedure" (Stip. ¶ 69). Plaintiff Dr. Broekhuizen testified that "D&X is never the only procedure that's available" (Tr. 84).

Based on the testimony elicited at trial, the parties' stipulation and the documentary evidence introduced into the record, there was no showing that limiting the availability of only the D&X method of abortion would pose a substantial obstacle or undue burden for women seeking abortions. Accordingly, if States' partial-birth abortion statutes are read appropriately to limit only the method of abortion that they address, there is no undue burden to women seeking abortions. "[W]hen state law offers many safe options" to women seeking abortions, "the regulation of an additional option does not produce an undue burden." *Hope Clinic v. Ryan* 195 F.3d at 871. The Eighth Circuit did not have the opportunity to reach this conclusion, but based on the record in the Wisconsin case, this is the conclusion this Court should reach.

CONCLUSION

For the reasons stated above, the judgment of the Court of Appeals for the Eighth Circuit should be reversed.

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